Testimony of

THE NATIONAL RURAL HEALTH ASSOCIATION

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Good afternoon. My name is Hilda Heady and I am here representing the National Rural Health Association (NRHA) as the 2005 president. I want to thank Chairman Dorcas R. Hardy *(in absentia)* and the members of the Policy Committee on Aging for the opportunity to testify before you on the topic of rural aging.

My remarks will focus on access to health care for the elderly in rural communities. I will comment on both potential solutions, as well as areas in which the Federal government can become partners in our efforts to improve both access and quality for rural elderly.

The NRHA is a national nonprofit organization of more than 8,000 members, which provides leadership on rural health issues. NRHA works to create a clear national understanding of rural health care, its needs, and effective ways to meet them. The association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research.

The NRHA membership is made up of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health. Individual members come from all backgrounds and include community members, students, state level policy administrators, hospital and rural health clinic administrators, physicians, nurses, dentists, non-physician providers, health planners, researchers and educators. Organization and supporting members include hospitals, community and migrant health centers, state health departments, state offices of rural health and university programs. NRHA maintains a 30 member Rural Health Policy Board and the policy and issues papers of the organization are posted on the NRHA website at www.NRHArural.org.

It has been widely noted that the U.S. population is aging, with 77 million baby-boomers poised to enter the Medicare system in the coming years. The rural population of our nation is aging more rapidly because of elderly people aging in place, younger residents

leaving rural areas for metro areas and elderly citizens returning home to rural communities as they age. There are approximately 9.2 million people in rural America aged 65 and older. Rural elderly are less likely to have a high school education and more likely to be poor. Because rural residents tend to have lower lifetime incomes than their metropolitan counterparts, their Social Security benefits are subsequently less in many cases.

As you are well aware, rural areas are unique. They differ from urban areas in their geography, population mix and density, economics, lifestyle, values and social organization. Rural areas are viewed as vulnerable to reduced access to health care for a variety of reasons. These reasons include limited numbers of providers, poorly developed health care systems, high prevalence rates of chronic illness and disability, socioeconomic hardships, and geographic and transportation issues.

Rural areas also differ from urban areas in the way that health care services are delivered to residents. Small, rural hospitals, in addition to being the only source of emergency care, are often a community's only resource for health care services such as long-term care, home health services, and outpatient services. Rural residents tend to have access to a narrower and more costly range of health care services and to be served by fewer health care providers. Rural people and communities require programs appropriate to their individual characteristics and needs and often utilize innovative and creative collaborations to meet their health care needs.

Rural is not just different; it is special

While my message is about rural being very different than urban with unique challenges, my message is also that rural is special, very special. And it is just that special part of rural that we can look to for needed solutions in rural areas. There are tremendous strengths within the rural American culture that serve us well when designing solutions. Rural people value their families and their roots; they have a sense of place, community, and service to one another; they maintain a sense of beauty and a sense of humor; they also value their independence as well as a collaborative bond in adversity. Rural people

are patriotic and modest. These are all values which any solutions to the challenges of societal and individual aging should address.

General Needs of the Rural Elderly

The major issues for the rural elderly are access to health and other services, housing, and transportation (not only for health care services but for needs of daily living such as shopping, recreation, etc.) West Virginia has become the oldest country in the nation. One of our fastest growing segments of the population is women over the age of 85. These elderly women cannot maintain their homes so housing and a safe household environment become critical. Younger people migrate from rural areas leaving their elderly relatives on their own to try to maintain the homestead.

Medicare

Because the elderly make up a larger proportion of the rural population, Medicare assumes a greater role as a source of financing for health care in rural areas. However, Medicare spends more on urban than rural beneficiaries and in many cases, pays less for the same service provided in a rural as opposed to urban setting. Compared to the national average, Medicare per person spending is 85% of the national average for rural beneficiaries and 106% for urban beneficiaries. Taking into account all of the Medicare rate adjustments, average rural hospital payments are 40% less than urban hospital payments and 30% less for physician payments.

PACE: A Rural Possibility

As this hearing is focused on solutions, it is critical to discuss the possibility of extending the PACE model into rural areas. NRHA and the national PACE organization held a summit in 2002 and produced a joint policy statement entitled, "*Setting the PACE for Rural Elder Care: A Framework for Action.*" This policy brief outlines the potential for adaptation of the PACE model for rural communities by drawing on the strengths of rural values as requisite pieces for these models. The PACE model requires collaboration, trusting relationships, a sense of, and commitment to community, and cooperation. The 22 year old, urban model for Programs of All-inclusive Care of the Elderly (PACE) can be well adapted to rural areas with some modifications. These modifications include

alternative centers approaches, linked providers, nontraditional providers, creative partnerships, flexibility for expanded populations, and considerations for risk management. CMS could develop a rural demonstration program which could employ rural models. The two which seem most appropriate are the Rural Network Model and the Rural-Urban Linkage Model. The Rural Network Model could overcome several obstacles: interdisciplinary team members could come from multiple agencies and even outside the community, facilities and equipment could be shared among network members, network services and arrangements could be piggybacked to use excess or unused capacity; network members served larger areas and so the population based needed to support the PACE could be reached more easily. The Rural-Urban Linkage Model could be either with existing PACE programs to expand coverage areas into rural areas with satellite operations or new PACE programs that connect rural needs with urban resources. This model would have these advantages: specialized services not available in urban areas could be made available; administrative costs could be spread over a larger population; financial risk could be shared across urban and rural populations; and community resources provided by and known to rural providers could be utilized, thus strengthening these existing services. These demonstrations would require start up funding and technical assistance.

Prescription Drug Benefit

There are two very critical issues related to prescription drug benefits for the elderly; these are containing the cost of out of pocket expenses and providing and maintaining the whole package of pharmaceutical care. Comparing rural to urban beneficiaries in 1999, rural beneficiaries spent 10% of their income out of pocket on prescription drugs, while only 8% of urban beneficiaries did so. The full impact and benefit of the Medicare Prescription Drug benefit is yet to be seen in rural areas, however, many concerns remain that the current program falls short of providing and maintaining full pharmaceutical care for rural elders. This type of care includes patient advice so critical with rural elderly, clinical services which can range from screenings and diagnostic testing, case management where pharmacists routinely consult with a patient's physician, and benefits management where the pharmacist consults with insurance agencies and runs interference

for patients with third party payers. Many independent, local pharmacies provide full care to the elderly patients and many know these patients and provide culturally aware and sensitive care to the elderly. Most of the elderly can get prescription drugs through mail order services; these services do not provide full care and advice. While 20 to 25% of our population lives in rural areas only 12% of the nation's pharmacists practice in rural areas. Seventy percent of the small, independent pharmacies in the country are located in communities under 50,000.

Meeting Post Acute Care Needs in Rural America

Rural health care services must address the full continuum of care, including post-acute care in settings such as skilled nursing facilities and swing beds, as well as care provided in the patient's home. Recommendations for changes and improvements include:
The Department of Health and Humans Services (DHHS) should conduct research on access to post-acute care in rural areas and the provision of services to elderly who wish to remain in their homes. CMS should simplify existing regulations for swing beds. CMS should extend the time limit to do an assessment once a home health patient is admitted in rural areas. DHHS should conduct research (including data from rural providers) to determine if inadequate Medicare or Medicaid reimbursement limits access to post-acute care in rural areas. Congress should permanently extend the 5% rural home health bonus payment. Payment rates for home health care providers in rural areas should address the longer travel distances in rural and frontier areas. CMS should allow occupational therapy as a qualifying skill in home health care. Programs such as the Health Professions programs in Title VII and VII of the PHS Act should be reauthorized and strengthened to encourage and prepare more health professionals to serve rural underserved areas. Community colleges should be encouraged to expand training of allied health providers to provide post acute care.

The Aging Rural Veteran and their Families

We know that a significant number of veterans come from and live in rural areas of the country. The national percentage of veterans within the US population is 12.7% and over 18 predominantly rural states have rates at 14 to over 16%. Most of these states are in the

west and south where rural health needs are the greatest. As our veterans are aging, we need to give great consideration to the long term care needs of these veterans. The need for more readjustment outreach centers and their services for the aging Vietnam era baby boomers is increasing. The average age for this vet is now 58. The Vietnam Veteran represents the largest segment of our total veteran population at 8.4 million or 31.7%. The VA and other systems of care are feeling the pressure of aging veterans. Between 1996 and 2003, vets seeking care within the VA system increase by 134%. In a VA study comparing 8 measures of physical and mental health, rural veterans were less healthy than urban veterans while both were less healthy on these measures than the national adult population. Rural veterans ranked 33, urban veterans ranked 37, while nationally individuals ranked 50 in physical health. We know that PTSD from combat has created problems for veterans and contributed to homelessness in both rural and urban communities. Veteran Readjustment Centers around the country are experiencing an increase in the number of vets seeking help for acute on-set of PTSD related symptoms as they age. PTSD impacts not only the veteran but also his or her loved ones as well, and the symptoms of PTSD can increase with age. I have much concern for the rural veteran who is isolated, suffering from PTSD, and physical health problems. This individual's family might not remain in tact, and as he ages, his support system will decline. There are very limited mental health services available for him and nursing home beds if he needs them. More research is needed to study the health and mental health needs of the aging veteran and his family.

Partnerships and Collaboratives

Partnerships, networks, collaboratives, and other cooperative approaches among rural providers can address some of the fragility of the rural health care landscape and can engage rural consumers in health care and policy development. These approaches have been used extensively to create wellness and health promotion programs for the elderly and other rural populations. The strategies of engagement, equanimity, and empowerment makes sense to rural people for these reflect the rural values of working together for the common good in the face of adversity. Any federal approaches which advocate and support the development of partnerships for rural health education, and for

wellness and health promotion should be given serious consideration as a viable mechanism to address the health care problems of the rural elderly.

Examples of Solutions and Practices for the Rural Elderly

Programs that promote local innovation and development of local resources, engage the elderly in planning, implementing, and dissemination, and build partnerships among resources and citizens are generally the most successful. Among the most important factors in assuring access to services in rural areas are identification and maximization of existing resources. Local volunteers are a valuable potential resource in every community. With specialized training they can provide nearly every population with basic needs and support services. Such an arrangement benefits both the volunteers and the service recipients and can strengthen the community bonds of both parties. Volunteers in Calhoun County, West Virginia were recruited to assist in this program and prior to providing transportation to services for older people in remote areas, requested education and training in coping with sudden health problems that might occur in the course of a journey. After such education and training they provide the volunteer service on a daily basis. Many extended families in the area use the services of the Adult Day Care program for respite and for social activities for their elderly loved ones.

The Federal Office of Rural Health Policy through its Rural Health Outreach Grants has fostered innovation in the use of local resources for services to the elderly. Three such programs, in Idaho, Iowa, and Georgia are also examples of best practices in the use of local resources. In Moscow, Idaho the Adult Day Health Program provides a continuum of appropriate health and therapeutic services, recreational activities, nutritional services, psychosocial support, and educational activities in a safe, caring, stimulating environment. The primary target populations for this program are African American (1%), American Indian (3%), Caucasian (90%), and Hispanic (5%). A collaboration of regional health and human services agencies provides additional support, expertise, and ancillary services. The program's targeted population is the frail elderly, the developmentally disabled and severely impaired adults of the service area. The overall goals of the center are to maintain and improve the physical health status and activity

level, improve the psychosocial health status and activity level, and improve participants' ability to perform activities of daily living and remain in the home community with an optimum level of independence. To achieve these goals the center extends services to geographically and socially isolated residents; coordinates services with other providers; provides transportation and well-trained staff escorts to allow participants to attend appointments for other services; and provides assistance, education, and psychosocial support to family members and caregivers of the targeted population.

The North Iowa Mercy Health Center in Mason City provides expanded health care services to seniors in 15 counties in northern Iowa. The project recycles and repairs assistive technology equipment to clients who are unable to afford new durable medical equipment or the repair costs of their existing equipment. The project also develops a multi-provider clinic to ensure local access to physician, therapy, and dental services. This site also provides the focal point for the equipment outreach that is done both at the clinic and in the homes of needy seniors. The project is also developing an education initiative to promote the project and the equipment and health care services available to local residents.

West Virginia maintains a 14 year old partnership of rural communities, state agencies, and higher education in an effort to increase the number of health providers in practice in rural underserved areas of the state. From 1999 to 2004 the state have seen an increase of 88% in the number of rural physicians giving an annual rate of increase of 13.4%, and a total of 661 health professionals in these areas since implementing the state required rural rotations under this partnership. The West Virginia Rural Health Education Partnership (WVRHEP) has helped recruit these 661 health professionals in rural underserved areas of the state. These health professionals include: 165 physicians, 130 pharmacists, 96 nurses, 70 dentists, 78 PAs, 64 NPs and nurse educators, 35 physical therapists, 17 dental hygienists, 4 medical technologists, 1 certified nurse midwives, and 1 occupational therapist. Critical to this partnership are the local rural organizations and community leaders with compatible missions, goals and objectives, who, with the health sciences centers, are willing to provide faculty/preceptors, learning resources and technical

support for the students and trainees. Also, WVRHEP enters into contracts and affiliation agreements with community providers and organizations to support student and resident training. Today, WVRHEP's infrastructure, which supports the WV AHEC program, consists of 12 regional partnerships, each with its own board and serving 50 of WV's rural underserved counties. With the joint effort of the WV AHEC/WVRHEP programs, we hope to be able to offer medically underserved communities in all 55 counties the same opportunities for continuing medical education and improvements to the quality of health care delivery in rural areas. Within these 12 consortia, 367 training sites as partners; 215 of these training sites are located in communities with a federal designation as a Health Professions Shortage Area (HPSA) or a Medically Underserved Area (MUA) or serve primarily underserved populations. These training sites include 28 community health centers (CHCs), 32 federally qualified health centers (FQHCs), 29 rural health clinics (RHCs), 30 small rural hospitals, 25 dental offices, 37 pharmacies, 13 county health departments, 20 physical therapy agencies or rehabilitation centers in underserved areas, and 16 county boards of education or school systems. There are 646 rural field faculty within this network.

The Partnership for Rural Elderly in Dahlonega, Georgia is a collaborative interdisciplinary effort committed to providing direct rehabilitation, consultative, and educational services to rural, low-income elderly citizens in the North Georgia region who do not otherwise have access to such care. This community is primarily Caucasian (96%). This program provides services within this underserved community to bridge the gap between medical care and quality of life. County Senior Center, Programs Assisting Community Elderly, Dahlonega Habitat for Humanity, Gainesville Aid Project, Georgia AHEC, and the Lumpkin County Commissioner.

The federal government can be helpful in the following ways:

- Ensure that the prescription drug benefit under Medicare is accessible and equitable for rural beneficiaries
- Improve reimbursement to home health and other community-based services that seek to keep the elderly healthy and at home.

- Develop and fund a PACE demonstration program for rural areas.
- Develop funding partnerships with state governments to encourage state to train health professional students in rural communities and engage in service-learning with the elderly while they train.
- Fund a national study on the rural aging veteran and their families with a focus to improve the outreach and readjustment center services in rural areas with a particular emphasis on mental health services.
- Improve funding to local communities who engage local resources to renovate the homes for the rural elderly.
- Provide increased funding for transportation programs that serve the rural elderly.

On behalf of the NRHA, I wish to thank the members of the Committee again for the opportunity to testify here today. As my testimony to you today indicates, good things are happening in our rural communities to help seniors obtain quality health care. I want you to know that the NRHA stands ready to work with your Committee and the Congress to ensure improved access to essential health care services for the elderly in rural and frontier communities. I would be happy to take any questions you may have.